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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/19/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: left wrist arthroscopy and ECU decompression

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified General Surgery; Fellowship: Orthopedic Hand and Upper Extremity Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is this reviewer's opinion that medical necessity for the requested left wrist arthroscopy and ECU decompression is not established at this time

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who has been followed for complaints of pain in the left wrist stemming from an injury on xx/xx/xx when she attempted to catch a x. The patient had received treatment for the left wrist to include bracing and the use of anti-inflammatories. The patient received steroid injections on 01/08/15 and had been referred for physical therapy. MRI studies of the left wrist which appear to have been performed in November of 2014; however, the actual date could not be discerned due to copy quality showed mild soft tissue edema adjacent to the distal aspect of the ulna. There was no indication of any ligamentous or tendon injuries. The report does show the TFCC to be intact. The patient was followed for persistent complaints of pain in the left wrist. The 01/27/15 clinical report found no specific findings for the left wrist. There was a repeat steroid injection performed at this evaluation. The clinical follow up on 02/10/15 noted persistent complaints of pain in the left wrist. No relief with injections was evident. The patient's physical examination found weakness on left wrist extension and left wrist flexion. There was tenderness over the dorsal and ulnar aspect of the left wrist. A positive axial load test was evident.

The requested left wrist arthroscopy to include ECU decompression was denied on 02/13/15 as there was no focal pathology of the extensor carpi ulnaris as well as any evidence of injury to the TFCC.

The request was again denied on 02/23/15 as there was no evidence on MRI studies of any ligamentous injury.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has had persistent left wrist pain despite conservative efforts to include bracing, injections, and medications such as anti-inflammatories. MRI studies of the left wrist failed to identify any particular pathology at the ECU that would reasonably require a surgical intervention. Although the most recent physical examination findings did note weakness and loss of range of motion with tenderness in the left wrist, these findings do not correlate with any specific pathology on MRI that would warrant surgical intervention. As this prior concern was not addressed in the clinical records submitted for review, it is this reviewer's opinion that medical necessity for the requested left wrist arthroscopy and ECU decompression is not established at this time and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)